Rhode Island Department of Health Tuberculosis Reporting Form

Confirmed & suspected cases of TB are reportable immediately upon confirmation or w/in 48 hours of suspicion.

Demographics	Status at Diagnosis of TB: ☐ Alive ☐ Dead
Name (Last, First, Middle):	
Street/Apt:	DOB (mm/dd/yyyy) / /
City:	Phone 1
State/Zip:	Phone 2
Ethnicity: ☐ Hispanic ☐ Not Hispanic	Gender ☐ Male ☐ Female
Race (one or more): ☐ American Indian or Alaska Native ☐ Asian:	☐ Black/African American ☐ White ☐ Native Hawaiian or Other Pacific Islander:
Country of Origin: ☐ US ☐ Not US (specify):	Month/Year Arrived in U.S.: (mm/yyyy) /

Disease Information				
Previous TB Diagnosis: ☐ Yes ☐ No	If Yes, Year of Previous TB Diagnosis (yyyy):		>1 Previous Episode ☐ Yes ☐ No	
Major Site of Disease:	☐ Pulmonary ☐ Pleural ☐ Lymphatic: Cervical	☐ Lymphatic: Intrathoracic ☐ Lymphatic: Other ☐ Lymphatic: Unknown	☐ Bone &/or joint ☐ Genitourinary ☐ Miliary	☐ Meningeal ☐ Peritoneal ☐ Other:
Additional Site(s) (check all):	☐ Pulmonary ☐ Pleural ☐ Lymphatic: Cervical	☐ Lymphatic: Intrathoracic ☐ Lymphatic: Other ☐ Lymphatic: Unknown	☐ Bone &/or joint ☐ Genitourinary ☐ Miliary	☐ Meningeal ☐ Peritoneal ☐ Other:
Sputum Smear:	☐ Positive ☐ Negative ☐ Not Done ☐ Pending		Lab: ☐ DOH ☐ Other:	
Sputum Culture:	☐ Positive ☐ Negative ☐ Not Done ☐ Pending		Lab: ☐ DOH ☐ Other:	
Smear Tissue/Other Site:	☐ Positive ☐ Negative ☐ Not Done ☐ Pending		Lab: ☐ DOH ☐ Other:	
Culture Tissue/Other Site:	☐ Positive ☐ Negative ☐ Not Done ☐ Pending		Lab: ☐ DOH ☐ Other:	
Chest X-Ray: ☐ Normal ☐ Abnormal ☐ Not done			Chest X-ray (if abn) ☐ Stable ☐ Worsening ☐ Improving	
Chest X-Ray (if abnormal): ☐ Cavitary ☐ Noncavitary (Consistent with TB) ☐ Noncavitary (NOT Consistent with TB)				
Tuberculin Skin Test at Diagnosis: ☐ Pos ☐ Neg ☐ Not Done			If TST Negative, was Patient Anergic? ☐ Yes ☐ No	
TST Millimeters of Induration:				

Risk Factor Information				
Resident of Correctional Facility at Time of Diagnosis: ☐ No ☐Yes			If Yes: ☐ ACI ☐ Juvenile Correctional Facility	
Resident of Long-Term Care Facility at Time of Diagnosis: ☐ No ☐ Yes	If Yes: ☐ Nursing Home ☐ Hospital-based Facility		☐ Residential Facility Facility ☐ Mental Health Residential Facility	☐ Alcohol/Drug Treatment Facility ☐ Other Long-Term Care Facility
Homeless Within Past Year: ☐ No ☐ Yes			Non-Injecting Drug Use within Past Year: ☐ No ☐ Yes	
Excess Alcohol Use within Past Year: ☐ No ☐ Yes			Injecting Drug Use within Past Year: ☐ No ☐ Yes	
Occupation (check all that apply within past 24 months):	☐ Health Care Worker ☐ Correctional Employee	☐ Migratory Agricultural Worker ☐ Other Occupation:	☐ Not Employed w/in past 24 months (retired, student, homemaker, unemp)	
Employer:				

Medication Information			**Comments/Clarifications on Patient, Diagnosis, Meds**
Date Therapy Started (mm/dd/yyyy)			
Isoniazid	☐ No	☐ Yes: Dose mg.	
Rifampin	☐ No	☐ Yes: Dose mg.	
Pyrazinamide	☐ No	☐ Yes: Dose mg.	
Ethambutol	☐ No	☐ Yes: Dose mg.	
Streptomycin	☐ No	☐ Yes: Dose mg.	
Other:		Dose mg.	

Reporting Information	
Reported by:	Telephone Number:
Reporting Facility:	Date of Report

Fax to TB Program, 401-222-2478 or **Mail to Rhode Island Department of Health**
(Call 401-222-2577 with questions.) **TB Program, Room 106, 3 Capitol Hill, Providence, RI 02908**

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